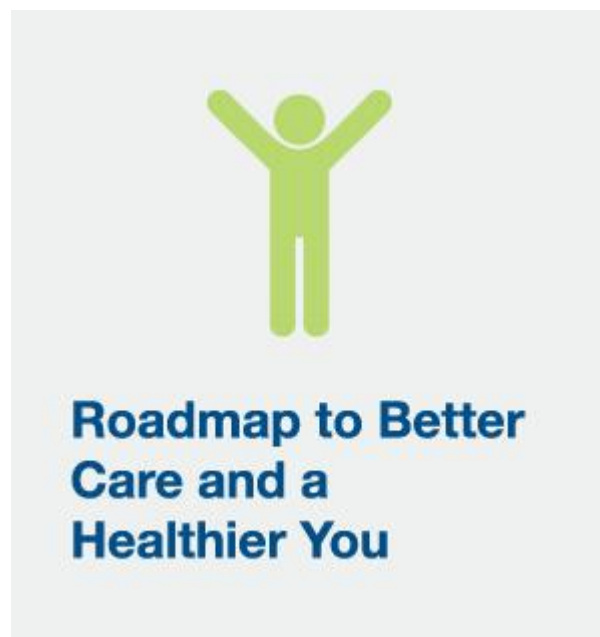
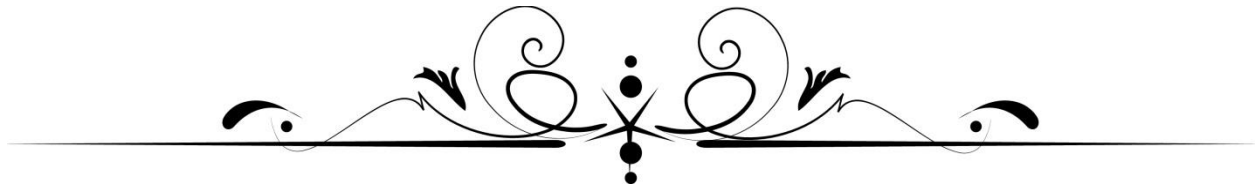


Patient Protection and Affordable Care Act (ACA): Cancer Prevention Summary



May 2017



Report Information

Title Patient Protection and Affordable Care Act (ACA): Cancer Prevention Summary

Description: The goal of this report is to summarize cancer preventive services covered by the ACA to share with the Missouri Cancer Consortium (MCC) and other partners to inform and encourage Missourians to seek cancer preventive care and engage in screenings.

Audience: This report is intended for use by the general public as well as state and local policy makers, researchers, local public health agencies, health care personnel, voluntary organizations and others interested in cancer prevention and screening services covered by the ACA.

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Introduction

For more than three decades, the US Preventive Services Task Force (USPSTF) has made recommendations regarding clinical preventive services for asymptomatic adults and children in primary care, based on rigorous analysis of the best available evidence.^{1,2} The USPSTF aims to improve the health of the public and help ensure access to preventive care. The USPSTF approach aligns with the recommendations of the Institute of Medicine on using evidence from high-quality systematic reviews and maintaining strict conflict of interest standards.^{3,4} The recommendations of the Task Force include a specific letter grade depending on the magnitude and certainty of net benefit compared to harm (Table 1).^{1,5} The Task Force does not consider the costs of a preventive service or insurance coverage implications when determining a recommendation grade. The recommendations apply only to individuals who have no signs or symptoms of the specific disease or condition under evaluation.

Table 1. USPSTF Recommendation Grades, Suggestions for Practice, and Relative Roles of the USPSTF, Lawmakers, and Insurers in Determining Coverage

USPSTF Role in Estimating Certainty of Net Benefit and Assigning a Grade				
Grade	Definition	Suggestions for Practice	ACA Linkage	Role of Insurers
A	Recommends (high certainty of substantial net benefit)	Offer or provide	ACA mandates coverage with no cost sharing	Establish coverage policy consistent with USPSTF grade and ACA ^a
B	Recommends (high certainty that net benefit is moderate or moderate certainty that net benefit is moderate to substantial)	Offer or provide		
C	Recommends selectively offering or providing to individual patients based on professional judgment and patient preferences (at least moderate certainty of small net benefit)	Offer or provide for selected patients depending on individual circumstances	ACA does not deny coverage and does not prohibit a plan from providing coverage ^a	Determine coverage policy based on effectiveness, consumer demand, community norms, and other considerations ^b
D	Recommends against the service (moderate or high certainty of no net benefit or that harms outweigh benefits)	Discourage the use of this service		
I	Concludes that current evidence is insufficient to assess balance of benefits and harms of the service; evidence is lacking, of poor quality or conflicting, and balance of benefits and harms cannot be determined	Read clinical considerations section of USPSTF Recommendation statement; if clinicians offer these services, patients should understand the uncertainty about the balance of benefits and harms		

Source: Evidence-Based Clinical Prevention in the Era of the Patient Protection and Affordable Care Act: The Role of the US Preventive Services Task Force. *JAMA*, 2015; 314(19):2021-2022. Doi:10.1001/jama.2015.13154 American Medical Association©

ACA: Affordable Care Act; USPSTF: US Preventive Services Task Force

^a Breast cancer screening for women in their 40s currently has a separate mandate for coverage with no cost sharing.

^b Coverage policy might include specifying the actual service and target population, which clinicians can provide the service; and where, when, and how often they can provide it.

The health care reform law passed in 2010, the Patient Protection and Affordable Care Act (ACA), also known as “Obamacare”, created a link between the USPSTF recommendations and various coverage requirements as shown in Table 1.¹ The ACA specifies that commercial and individual or family plans must, at a minimum, provide coverage and not impose cost sharing for any evidence-based preventive services that receive a grade of A or B from the USPSTF. Public programs such as Medicare and Medicaid are excluded from this provision of the ACA. However, the ACA leaves discretion to payers regarding coverage for non-A and non-B graded services – as was the case for all preventive services prior to the ACA. The result is that implementation of the Task Force recommendations should lead to expanded access to highly effective, evidence-based preventive services.

The ACA Requirements for Coverage of Preventive Services

A key provision of the ACA is the requirement that private insurance plans cover recommended preventive services without any patient cost-sharing.⁵ In addition, individual and small group plans in the new health insurance marketplaces are also required to cover essential health benefits with the preventive and wellness services being just one category of these essential services.⁶ Overall, there are 14 categories of essential health services including outpatient, emergency room, hospitalization, mental health and substance use disorders, prescription medication, laboratory, preventive, and other services. The required preventive services come from recommendations from the following expert medical and scientific bodies:

- U.S. Preventive Services Task Force commissioned by the Agency for Healthcare Research and Quality
- The Advisory Committee on Immunization Practices (ACIP) convened by the Centers for Disease Control and Prevention
- Health Resources and Services Administration’s (HRSA’s) Bright Futures Pediatrics Recommendations
- HRSA and the Institute of Medicine (IOM) Committee on women’s preventive services

Lawmakers provided a mechanism for prioritizing services for enhanced coverage by linking recommendations from these four expert medical and scientific bodies to coverage because having insurance and a breadth of coverage affects a patient’s use of the preventive services. The requirements that insurers cover preventive services recommended by USPSTF, ACIP and Bright Futures program went into effect for non-grandfathered plans with plan-years beginning on or after September 23, 2010.⁵ The coverage requirements for women’s clinical preventive services became effective for plans starting on or after August 1, 2012. New or updated recommendations issued by these expert panels are required to be covered without cost sharing beginning in the plan year that begins on or after exactly one year from the latest issue date (i.e., if the latest issue was on February 2013, the recommendations are required to be covered without cost sharing beginning on February 2013 or February 2014). If the recommendation is changed during a plan year, an issuer is not required to make the change mid plan year, unless one of the recommending bodies determines that a service is discouraged because it is harmful or poses a significant safety concern. In these circumstances, a federal guidance will be issued.⁵



The cancer preventive and wellness services endorsed by the USPSTF, ACIP, Bright Futures, and HRSA-IOM are provided with no cost-sharing to the individual under the ACA.

Grandfathered Health Plans

These are group health plans that were in existence or an individual health insurance policy that was purchased on or prior to March 23, 2010. Plans or policies may lose their “grandfathered” status if they make significant changes to their coverage (e.g., increasing patient cost-sharing, cutting benefits, or reducing employer contributions) or change in ways that substantially cut benefits or increase costs for plan holders.⁷ If a person has a grandfathered plan, they may not get some rights and protections that other plans offer. The insurer is required to disclose in its plan materials and notify consumers if it is a grandfathered plan and advise how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

If a health plan is Affordable Care Act – compliant – meaning the coverage started after March 23, 2010, many cancer screenings and vaccinations are available at no cost to the person if they stay within their insurance network.⁸ All marketplace health plans and many other plans must cover the following summary of preventive services without charging a copayment or coinsurance. This is true even if the yearly deductible has not been met, so long as these services are delivered by a doctor or other provider in the individual’s plan network^{9,10,11}

ACA Cancer Preventive Services for Adults and Children

Preventive care focuses on evaluating an individual’s current health status when the person is symptom free. The Affordable Care Act required that all major medical health insurance policies cover certain preventive services.

- For adults, there are 18 preventive care benefits listed and broadly include screenings, counseling, immunizations, and aspirin use.
- For children, there are 27 preventive care benefits listed covering assessments, screenings, counseling, immunizations, supplements, and medication.
- For women, there are 11 preventable services available for free for pregnant women or women who may become pregnant with an additional 15 benefits listed for all women younger than age 65. Well-woman visits are provided on an annual basis and include a full checkup. Multiple well-women visits may be required to fulfill all necessary preventive services and should be provided without cost sharing as needed, determined by clinical expertise.

Many of the covered preventive services benefits relate to cancer prevention. A summary of the cancer preventive services covered by non-grandfathered private plans without cost sharing so long as they use their insurer's provider network are described below.^{5,12,13}

Screening and Early Detection

Breast Cancer

Breast Cancer -Testing and medications for risk reduction of breast cancer – Women with family history of breast, ovarian or peritoneal cancer should be screened for BRAC-related cancer, and those with positive results should receive genetic counseling and genetic BRCA testing when appropriate.

As long as the women has not specifically been diagnosed with BRCA-related cancer in the past, genetic screening, counseling and testing should be covered without cost sharing when the services are medically appropriate and recommended by her provider.

USPSATF also recommends the provision of chemo-preventive medications for women deemed to be at high risk. As such, risk-reducing medications, such as tamoxifen or raloxifene, must be covered without cost sharing when prescribed to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

- Mammography (*women 40+*)^a
- Genetic (BRCA) screening and counseling (*women at high risk*)
- Preventive medication (chemoprevention) and counseling (*women at high risk*)

Cervical Cancer

- Pap testing every 3 years (*women age 21-65 with cervix; 66 and older discuss with health provider*); if both Pap test and HPV test completed at the same time then every 5 years
- Human Papilloma Virus (HPV) DNA test (*women age 30-65 with normal Pap test results; can be done with same specimen for Pap test but has to be ordered by provider*). HPV testing is also available for men 18-21 years of age not previously vaccinated and at risk men 22-26 years of age.
- Cervical dysplasia screening for sexually active female children

Lung Cancer

- Annual low-dose computed tomography (*adults age 55-80 with 30 pack-year smoking history and currently smoke or have quit within the past 15 years*)

^a The ACA defines the recommendations of the USPSTF regarding breast cancer services and recommends women aged 40-49 talk with their doctor about when to start getting mammograms and how often to get them. Women aged 50-74 get mammograms every 2 years and talk with your doctor to decide if you need them more often. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older.

Liver Cancer

- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S. born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence; and for pregnant women at their first prenatal visit
- Hepatitis C screening for adults at increased risk, and one-time for everyone born 1945-1965

Skin Cancer

- Counseling (*adults age 18-24*)

Colorectal Cancer

Screening for colorectal cancer using colonoscopy receives an “A” rating from the USPSTF. Under the Affordable Care Act, most insurance plans must cover screening for colorectal cancer.¹⁴ However, insurers may or may not impose cost sharing for medically necessary anesthesia services and polyp removal performed in connection with the preventive colonoscopy in asymptomatic individuals, so it is best to talk to the insurance company to find out what is covered by the plan before being screened.

- Fecal occult blood testing, sigmoidoscopy and/or colonoscopy (*Adults age 50-75*)

Kaposi's Sarcoma

Kaposi sarcoma (KS) is a cancer that develops from the cells that line lymph or blood vessels. It usually appears as tumors on the skin or on mucosal surfaces such as inside the mouth, but tumors can also develop in other parts of the body, such as in the lymph nodes (bean-sized collections of immune cells throughout the body), the lungs, or digestive tract. The abnormal cells of KS form purple, red, or brown blotches or tumors on the skin. This cancer often develops in people who are infected with HIV, the virus that causes AIDS. Through the counseling and screening process the cancer may be detected.

- HIV screening and counseling is available for everyone aged 15 to 65, and other ages at increased risk

Primary Prevention

Tobacco

The USPSTF has guidelines for tobacco counseling for the following population groups: adults who are not pregnant, all adults including pregnant women, and school-aged children and adolescents.

In non-pregnant women and adults, the USPSTF found convincing evidence that smoking cessation interventions, including brief behavioral counseling sessions and pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit and remain

abstinent for one year. Although less effective than longer interventions, even minimal interventions have been found to increase quit rates.

- Tobacco use screening for all adults and cessation interventions for tobacco users

In pregnant women, the USPSTF found convincing evidence that smoking cessation counseling sessions, augmented with messages and self-help materials tailored for pregnant smokers, increases abstinence rates during pregnancy compared with brief, generic counseling interventions alone. Tobacco cessation at any point during pregnancy yields substantial health benefits for the expectant mother and baby.

- Expanded pregnancy-tailored tobacco intervention and counseling

For more information go to:

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions>

The USPSTF found adequate evidence that behavioral counseling interventions, such as face-to-face or phone interaction with a health care provider, print materials, and computer applications, can reduce the risk of smoking initiation in school-aged children and adolescents. The USPSTF concludes with moderate certainty that primary care–relevant behavioral interventions to prevent tobacco use in school-aged children and adolescents have a moderate net benefit.

- Tobacco counseling and cessation interventions (*children 5 years of age through adolescents*)

For more information go to:

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions>

Obesity

- Screening for children age 2 and older
- Counseling and behavioral interventions for children 6 years of age or older
- Obesity screening, counseling, and management - Referral for intervention for adults with a body mass index (BMI) > 30kg/m²

Diet

- Counseling for adults at high risk for chronic disease

Oral Health

- Risk assessment and referral to dental home

Special Populations

Medicare Part B covers colorectal cancer, mammography, prostate cancer screenings and a one-time Welcome to Medicare preventive visit.

- If you have Medicare some charges may apply depending on the type of colorectal screening test, [find out about Medicare coverage for different colorectal cancer tests](#).
- If you have private insurance, talk to your insurance company to find out what's included in your plan. Ask about the Affordable Care Act.
- If you don't have insurance, you can still get important screening tests. To learn more, [find a community health center near you](#).

Other Health Services May Have a Cost

If the office visit and the preventive service are billed separately, cost sharing cannot be charged for the preventive service, but the insurer may still impose cost-sharing for the office visit itself. If the primary reason for the visit is not for preventive services, patients may have to pay for the office visit and the other health services received, so be sure to indicate the visit is for preventive services only. However, if a treatment is given as the result of a recommended preventive service, but is not the recommended preventive service itself, cost sharing may also be charged.

For example, if you bring your child to the doctor, and he receives a shot, that immunization may be free but the office visit itself may not, depending on the primary diagnosis or reason why you brought your child in (sick child, yearly check-up, etc).⁸

Another example, if a screening colonoscopy or screening flexible sigmoidoscopy results in a biopsy or removal of a lesion or growth (polyp) during the exam, the screening is free but the procedure to remove the polyp may be considered diagnostic and you may have to pay coinsurance and/or a copayment.

Conclusion

As of February 2015, it was estimated that 137.7 million Americans had preventive services coverage without cost sharing.¹⁵ In Missouri, the number was estimated at 2.8 million people with this coverage. In 2014, 26% of workers covered in employer sponsored plans were still in grandfathered plans, but it is expected that over time almost all plans will lose their grandfathered status and more people will have coverage for preventive services.⁵ Unfortunately, more than one-third (35%) of Americans don't know that ObamaCare and the ACA are the same¹⁶ and many are unaware (43%) that the ACA eliminates out-of-pocket expenses for preventive services.¹⁷ Efforts are needed to educate the public regarding these issues and promote engagement in preventive care.

With the potential to repeal and replace the ACA, if preventive services are not allowed, it potentially would negatively impact the population's health for several reasons including:

- All free preventable services may no longer be available for free and individual states may elect not to offer the preventive services at all.
- Waiting to treat illness until a person is sick, instead of focusing on prevention, has a direct effect on the public's health and may raise health care costs in the U.S.
- For the many, preventive exams are a luxury that most will not be able to afford and will be at risk of losing these services and poorer health in the long run.

In summary, the ACA, while not perfect and with some flaws, assures essential health services and provides no-cost preventive care which is likely to benefit the health of millions.

To learn more about the Affordable Care Act Visit, HealthCare.gov

and

Obamacare Preventive Care <http://obamacarefacts.com/obamacare-preventive-care/>

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